ConnPIRG
Standing Up
To Powerful Interests

198 Park Rd., 2nd Fl.
West Hartford, CT 06119

www.connpirg.org
info@connpirg.org

(860) 233-7554 (ph)
(860) 233-7574 (fx)

Testimony of Jennifer Hatch, Program Associate
Connecticut Public Interest Research Group (ConnPIRG)

Before the Connecticut General Assembly Insurance and Real Estate Committee

February 17, 2011

Testimony Regarding S.B. 11, "An Act Concerning the Rate Approval Process for Health Insurance Policies"

Senator Crisco, Representative Megna, Members of the Committee,

Thank you for the opportunity to offer testimony regarding S.B.11, An Act Concerning the Rate Approval Process for Health Insurance Policies. ConnPIRG is a statewide member-supported consumer advocacy organization that stands up to powerful interests, working to win concrete results for the health and well-being of Connecticut's residents. We've worked nationwide to rein in the soaring costs of health care for individuals and small businesses, and a vigorous process for considering health insurance rate increases is a key measure to controlling costs.

Last year's approval of Anthem's excessive 47% rate hike highlights the necessity of strengthening our rate approval process. Our sister organizations in California and Oregon have been instrumental in establishing and strengthening rate review systems in those states, and Connecticut should adopt some features of those states' systems in improving our own.[i]. There are two critical principles for a strong rate review system that can address the rising cost of our healthcare system and protect residents from excessive rate increases:

1. Regulators must set strong standards and push insurers to lower premiums and improve the quality of coverage.

In order to raise premium rates, health insurance companies must meet high standards showing they are operating as efficiently as possible, that they are making an effort to cut wasteful spending, and that any rate hike is necessary, justified and not excessive.

In deciding whether to approve or reject an application for rate increase, regulators should have the authority and the mandate to take all considerations into account, making a holistic determination. In particular, the costs of an insurer's inaction or bad practices should not be passed onto the consumers – specific examples would include cases where insurers continually fail to adopt cost-saving reforms, set their administrative expenses to increase faster than the Consumer Price Index, or increase rates to recoup the costs of being required to pay fines or damages for bad behavior.[ii]

2. Require Transparency and Public Participation

The process for approving insurance rate increases should be open to increased transparency and accountability. Connecticut's consumers and businesses must have

the opportunity to weigh in through a public comment period or public hearing before a rate increase is approved. To make this participation meaningful, the entirety of insurers' rate filings should be made publically available. Furthermore, the Attorney General and the Healthcare Advocate should be made a party to the rate review process, with full access to information and the authority to examine witnesses relating to the proposed increase.

We feel that S.B. 11 addresses both of these main principles and we offer the following comments regarding specifics sections of the bill.

With respect to setting strong standards to push for lower premiums and better quality:

We support the deletion of Section 1, subsections d, e and f of the bill (lines 46-118 inclusive), as the filing of a satisfactory loss ratio guarantee does not eliminate the possibility of an excessive rate increase. Striking these subsections and defining "excessive" as outlined in Section 6, beginning on line 307, offers stronger protection for consumers and a more vigorous effort to actually reduce wasteful spending.

The bill would be improved by further specifying the information insurers are required to provide when filing for a rate increase, to give the regulators more comprehensive information as they evaluate whether to accept or reject a proposed increase. A recent California law, enacted in September 2010[iii], listed 24 such requirements, including enrollment and rate changes broken down product by product, a breakdown of how the insurer determined medical trend, and changes in benefits, cost-sharing and administrative costs. The following list is the language from that law, and we submit this as an example for how these elements could be adopted in Connecticut:

b). A plan shall disclose to the department all of the following for each individual and small group rate filing:

(1) Company name and contact information.
(2) Number of plan contract forms covered by the filing.
(3) Plan contract form numbers covered by the filing.
(4) Product type, such as preferred provider organization or health maintenance organization.
(5) Segment type.
(6) Type of plan involved, such as for profit or not for profit.
(7) Whether the products are opened or closed.
(8) Enrollment in each plan contract and rating form.
(9) Enrollee months in each plan contract form.
(10) Annual rate.
(11) Total earned premiums in each plan contract form.
(12) Total incurred claims in each plan contract form.
(13) Average rate increase initially requested.
(14) Review category: initial filing for new product, filing for existing product, or resubmission.
(15) Average rate of increase.
(16) Effective date of rate increase.
(17) Number of subscribers or enrollees affected by each plan contract form.
(18) The plan's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost

increases in specific benefit categories in major geographic regions of the state. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(19) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans

(20) A comparison of claims cost and rate of changes over time.

(21) Any changes in enrollee cost-sharing over the prior year associated with the submitted rate filing.

(22) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.

(23) The certification described in subdivision (b) of Section 1385.06. *[note: this is an actuarial certification]*

(24) Any changes in administrative costs.

c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and small group health plan markets:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of subscribers.

(E) Number of covered lives affected.

(2) The plan's average rate increase by the following categories:

(A) Plan year.

(B) Segment type.

(C) Product type.

(3) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

Secondly, with a view to assisting regulators identify proposals that are likely to be problematic, we recommend that increases in administrative costs which exceed the rate of general inflation be considered an important factor in suggesting the increase is not reasonable. We further recommend sufficient justification that the increases are necessary and appropriate, or that such increases contribute to an increase in the quality of care provided.[iv]

We also recommend the establishment of guidelines for cases where insurers have had to pay out a significant regulatory fine or legal damages, as these financial losses should come out of profits, rather than being used as an excuse by the insurer to raise rates.

With respect to transparency and public participation:

We support Section 6a of the bill beginning on line 269, to provide online public access to documents related to the requested increase, as well as both a written public comment period and a public hearing for proposed rate increases. These provisions are robust opportunities for consumer involvement and not only guard against bad practices that can inflate rates, but also promote consumer confidence in insurance products.

With respect to Section 6 of the bill, beginning at line 284, we support the concept of public hearings regarding proposed rate increases, but feel that requiring a public hearing on each rate increase could be burdensome for regulators, forcing them to conduct hearings on increases that might affect only a few consumers, be relatively small and affordable, or represent technical changes in rating rules to comply with changes in state or federal law. The volume of such hearings could prevent regulators from devoting their resources to more important rate increases, where deeper review and more robust consumer participation is essential.

To concentrate regulatory efforts on the proposals that are most likely to have negative consumer impact, we suggest that the Insurance Commissioner set, each year, a specific, reasonable threshold above which all increases will receive a public hearing, and below which a public hearing may be held at the discretion of the Insurance Commissioner or at the request of the Attorney General or Healthcare Advocate. This allows consumers the opportunity to be heard on rate increases that are likely to be excessive, unreasonable, or pose an undue burden on consumers.

Furthermore, we support the provisions in Section 7 authorizing the Attorney General and the Healthcare Advocate to be parties to any hearing in regards to an insurance rate increase, as well as the measures to ensure full access to information and cooperation with these parties, to ensure a thorough review process with a strong voice for consumers.

On behalf of our members and all Connecticut's consumers, I urge the Committee to adopt these measures to create a more vigorous, transparent rate review process that allows both the general public and the Attorney General and Healthcare advocate, on their behalf, to take a comprehensive look at proposed rate increases, and help combat the rising costs of health care.

Thank you for the opportunity to share these comments, and I look forward to working with the Committee on this and other issues throughout the session.

Jennifer Hatch
ConnPIRG

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[i] California State Legislature. Senate Bill 1163, Adopted September 30, 2010; Available at: http://info.sen.ca.gov/pub/09-10/bill/sen/sb_1151-1200/sb_1163_bill_20100930_chaptered.pdf

[ii] Michael Russo, Keeping Insurers Honest: How California Can Stop Unreasonable Insurance Premium Hikes; California Public Interest Research Group, May 2010. Available at: http://www.calpirg.org/home/reports/report-archives/health-care/health-care/keeping-insurers-honest

[iii] California State Senate Bill 1163. 6-8.

[iv] Laura Etherton. Premiums on the Rise: An Analysis of Health Insurance Premium Increases and Small Businesses in Oregon. Oregon State Public Interest Research Group, May 2009. Available at: http://www.ospirg.org/home/reports/report-archives/health-care/health-care/premiums-on-the-rise-an-analysis-of-health-insurance-premium-increases-facing-individuals-and-small-businesses-in-oregon